OFFICE OF THE
HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND

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Dear Mr. Lynch, Mr. Hoesly, and Mr. Ross:

With respect to the upcoming 2012 small and large employer group rate factor review process for commercial health insurance issuers in Rhode Island, the State of Rhode Island Office of the Health Insurance Commissioner (OHIC) is providing the following guidance for the filing of information necessary for the Health Insurance Commissioner (Commissioner) to determine that an issuer's filing is complete.

1. Purpose

It is the intent of OHIC to continue to refine the rate factor review process that holds issuers with significant market shares in Rhode Island publicly accountable for meeting the standards set forth for them in statute and regulation. Of these standards, OHIC intends to place particular importance during this year's review process on the expectation that it has previously conveyed to issuers in a guidance letter dated December 1, 2011 to submit aggregate predicted medical trends that do not exceed four percent for either small group or large group business. This expectation was developed by OHIC pursuant to the rate review standards which require that rates be consistent with the proper conduct of an issuer's business, in the public interest, and in furtherance of OHIC goals with respect to the affordability of health insurance.

OHIC will examine each issuer's filings in light of this expectation, in addition to its customary analysis, and will take actions on the filings it deems necessary. As a reminder, the range of

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actions available to OHIC remains unchanged—from acceptance of the factors as filed, to proposing changes in rate factors to issuers, to calling for a formal administrative hearing. OHIC's goal in setting this expectation is to hold the state's issuers (and the providers with whom they contract) accountable for swift action to address the current unsustainable growth in medical expense that represents an economic burden for businesses and consumers looking to recover from the recent recession.

The culmination of the review process will be a decision of the Commissioner to approve an "expected overall average premium trend" for each issuer in the small group market and in the large group market. The expected overall average premium trend is the result of each issuer's approved rate factors, administrative costs, and contribution to reserves and profit for each market. The expected overall average premium trend is a rate cap—meaning that the actual weighted average of all issuer initial offers of renewal premiums for the same product must not exceed the Commissioner's approved expected overall average premium trend in each market (regardless of changes in the experience of a group or any demographic changes in group mix). Renewal premium offers for products with different benefit relativity factors will not be considered in calculating an issuer's "actual overall average premium trend." OHIC will monitor and evaluate renewals in the small group and large group markets for compliance with this standard.

2. Effective Period of Rate Factors

Rate factors resulting from this review process will be applicable for rates effective starting January 1, 2013 and continuing through December 31, 2013.

3. Timing

OHIC will review large group and small group rating factors contemporaneously. All materials called for here should be submitted to OHIC via the System for Electric Rate Form Filing by May 18, 2012. A decision on each issuer's filing is expected by July 2, 2012. This decision will either: (1) inform each issuer that OHIC will accept the filing or (2) will be an initial determination that the filing will not be approved. If the filing is accepted, the issuer need not do anything further. If, however, OHIC makes an initial determination that the filings will not be approved and provides guidance as to what would constitute an acceptable filing, the issuers will then have approximately two weeks to either: (1) refile based on OHIC's recommendation or (2) reject OHIC's initial determination and request a hearing. If an issuer does nothing, OHIC will deem the issuer to have requested a hearing.

4. Conditions

As permitted by law, OHIC reserves the right to attach conditions to its decisions regarding these rate factors. Depending on the nature of the conditions, OHIC may engage in a public review process prior to their adoption.

5. OHIC Authority

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Any hearing will be conducted pursuant to Rhode Island General Laws § 27-19-6, § 27-20-6, and § 42-62-13. As a result of the hearing, OHIC may approve, modify, or reject the rate factors filed by the issuers.

6. Standards Used by OHIC for Review

The filing must be consistent with the proper conduct of each issuer's business and in the interest of the public (Rhode Island General Laws § 42-61-13). It should comply with all the requirements of this letter and should include a form that substantially conforms to, and includes the elements contained in, the template appended to this letter. Failure to meet the standards outlined in this letter, including completion of the template, may result in a rejection of the filing and disapproval of the requested rates. Additional standards that OHIC will use for review of the rate factors are outlined in OHIC Regulation 2.

7. Documents to be Included in the Filing

The following documents must be included in the filing:

- **Small and Large Group Rate Filing Template (attached):** This template indicates the specific factors under review by OHIC. On the basis of insufficient enrollment and inadequate claims history in the market, an issuer may request one or more waivers from the template requirements upon demonstrating to the satisfaction of the Commissioner that unique circumstances warrant deviation from the template. In the absence of the Commissioner's approval, an issuer shall not alter the attached template.
- **Actuarial and financial analysis to justify the rate factors requested:** Issuers may use whatever format they deem appropriate for the actuarial and financial analysis submitted to support their case for the requested rate factors.
- **Rhode Island Annual Health Statement Supplement (attached):** This document provides for disclosure of enrollment, premiums, and medical expenses by health lines of business (insured, ASO/TPA, and other lines identified in the document) as well as disclosure of enrollment, premiums, and medical expenses by market for only the reporting issuer's comprehensive/major medical line of business. The information required for this form refers to calendar year 2011. Each issuer must file the information required by this form for the issuer's business, as well as business of its affiliated entities with covered lives in Rhode Island. Beginning with calendar year 2012, OHIC intends to require reporting of this information on annual basis by all entities with covered lives in Rhode Island.
- **Areas of Medical Expense Variation Form (attached):** The purpose of this form is to allow issuers to identify procedure-level drivers of medical spending among Rhode Island residents. Each issuer will list the top five procedures for which per capita spending is greatest for Rhode Island residents relative to the issuer's chosen benchmark, both in raw dollars and as a percent of benchmark. Issuers may choose a suitable benchmark against which to compare Rhode Island per capita spending and may also

choose the units of service. To ensure comparability of data, issuers shall report results at the aggregated procedure level. Further details on the expected analysis are provided on the attached form.

- **Provider Contracting Practices and Hospital Contracting Conditions Verification Questionnaire (attached):** The purpose of this questionnaire is to assess compliance with standard four of OHIC's Affordability Standards which consists of six conditions for issuer contracts with hospitals.
- **Administrative Costs Request (attached):** This document provides detail on small and large group administrative costs.
- **Health System Improvements Survey (attached):** OHIC Regulation 2 lists standards to be used by the Commissioner for the assessment of the conduct of issuers for their efforts aimed at improving the efficiency and quality of health care delivery and increasing access to health care services. This survey provides information to help the Commissioner assess the conduct of the issuers pursuant to these efforts.
- **Small group rate manual and an example of the manual applied:** Issuers must provide the manual they use to calculate rates for small group business. Additionally, an example that clearly illustrates how the methodology outlined in the manual is applied to generate a plan premium for a typical small group plan must be submitted alongside it. The purpose of this portion of the filing is to develop experience with the review and approval of plan-specific premiums for when Qualified Health Plans are offered on the Rhode Island Health Benefits Exchange starting in October 2013.
- **Small group products for which the rates project to increase 10 percent or more:** The Affordable Care Act—or ACA (Public Laws 111–148 and 111-152)—requires that individual and small group products with proposed rate increases of 10 percent or more be reviewed to determine if they are unreasonable, as defined by the law. Product is defined as a package of health insurance coverage benefits with a discrete set of rating and pricing methodologies that an issuer offers. Rate increase is defined as the average increase for all enrollees weighted by premium volume. Rhode Island is deemed to have an Effective Rate Review Program under the ACA and, therefore, OHIC's determination of whether a rate increase is unreasonable will be accepted by the federal government. While OHIC has not traditionally reviewed small group rates at the product level, the office is requesting that issuers provide—in whatever format they deem appropriate—a listing of small group products projected to increase 10 percent or more during 2013 based on the rate factors submitted. While product-specific information will be collected in accordance with ACA requirements, OHIC will not review or render product-specific decisions during this review process.

Other materials at the discretion of the applicant, which support its request and/or document the applicant's compliance with Section 9 of OHIC Regulation 2, may also be submitted in whatever format an issuer deems to be appropriate.

8. OHIC Review Process

OHIC will produce analyses based on the issuer filings and externally available data. The office will engage the services of a consulting actuarial firm, DeWeese Consulting, Inc., to review the filings, who may contact appropriate issuer officials with further questions. Your cooperation with these inquiries is expected and appreciated. Costs for these consulting services will be borne by the issuers in proportion to market share.

9. Public Input and Accessibility

OHIC will collect public comment as a part of the review process. As part of the public comment process, OHIC will convene a public meeting in the coming weeks to provide a forum for both oral and written comment in addition to collecting written comment on an ongoing basis through June 21, 2012. More details related to the public comment process will be released by OHIC shortly.

Issuers may request confidentiality on portions of the documents they submit as part of this filing. Confidentiality is granted in rare circumstances and in accordance with past OHIC rulings on confidentiality. Any issuer requesting confidentiality must provide a factual and legal analysis to support its request to the Commissioner, with a copy to OHIC's Executive Counsel, and a specific list of items to which confidentiality should apply. A blanket request for confidentiality for the entire filing will be rejected.

10. Amendments/Additional Filings

While we intend for this filing to be effective for a one-year period, issuers will be permitted to make additional filings in the coming months if they judge circumstances to have changed so significantly so as to warrant an updated filing. OHIC would review and render a decision on any such additional filings as expeditiously as circumstances allow.

If you have any questions regarding this letter or any of its attachments, please feel free contact Patrick Tigue at (401) 462-9643 or patrick.tigue@ohic.ri.gov. When responding to questions, OHIC will brief all issuers collectively where possible so as to ensure consistent information. Thank you for your cooperation with this process.

Very truly yours,

Christopher F. Koller
Health Insurance Commissioner